Keystone First

Community HealthChoices

Long-Term Services and Supports (LTSS) Provider Change Form

CURRENT PRACTICE INFORMATION

Practice name/individual name: _____
(Please circle one ↑)

Practice ID/individual ID: Keystone First CHC ID:_____ PPID#_____
(Please circle one ↑)

_____ _____ _____ _____
Contact person name (please print clearly) Phone Fax Email address

_____ _____ _____
Authorizing signature (provider/office manager) Today's date Effective date of change
Change will not be completed without signature.

PROVIDER CHANGE INFORMATION

Provide complete information. This request will be processed for Keystone First Community HealthChoices (CHC). If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this change form.

Type of change (please check all that apply):

☐ Adding an office location
☐ Changing an office location
☐ Fax change
☐ Name change only
☐ Phone number change
☐ Other (attach documentation)

PREVIOUS OFFICE INFORMATION

Keystone First CHC Provider ID

Name

Street address

City State ZIP

Service counties

NEW OFFICE INFORMATION

Keystone First CHC Provider ID

Name

Street address

City State ZIP

Service counties

BILLING LOCATION CHANGE ☐

Street address 1

Street address 2

Street address 3

City State ZIP

Phone Fax Email address

Federal tax ID

(Note: A change in federal ID requires a new W-9.)

CHANGE OF OWNERSHIP ☐

Legal business name of new owner and federal tax ID (requires new W-9) Effective date of ownership

Please mail this change form and supporting documents to Keystone First CHC, Provider Contracting Department, 200 Stevens Drive, Philadelphia, PA 19113